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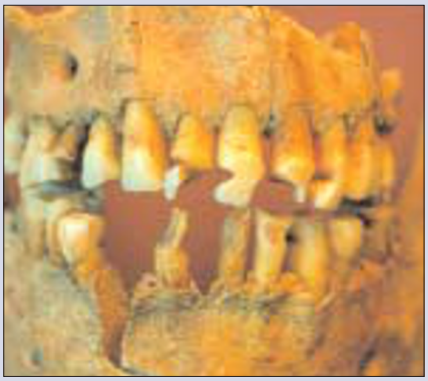
Priority will be given to letters less than 500 words long. Authors must sign the letter, which may be edited for reasons of space.

Unusual medieval dental abrasion



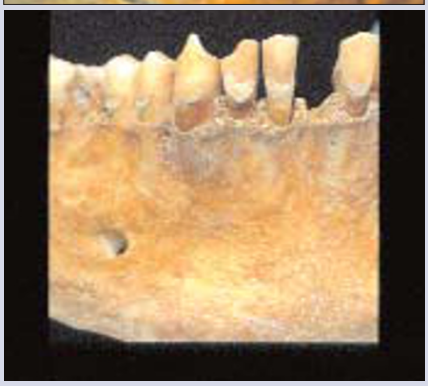


Fig. 1. Stonar (SK18): dentition showing abnormal, irregular marked abrasion, related to occupation? Fig. 2. St George's, Canterbury (SK 168): dentition showing smooth concave abrasion, the result of clay-pipe smoking.

Sir,– A male skeleton aged about 30-40 years excavated from a medieval cemetery at Stonar, near Sandwich in Kent displayed marked dental abrasion. The most severe changes involve the anterior maxillary teeth (Fig 1).

The right incisors display a wedge-shaped loss of enamel and dentine superior to the distal CEJ (cemento–enamel junction) and concave abrasion of the mesial aspect of their crowns. The larger distal defect on the central incisor is around 3mm deep with a maximum width of 3mm. The mesial abrasion of the lateral extends from the incisal edge to the CEJ. (Fig 1). The mesial and distal aspects of the left central incisor display marked abrasion. Only a 1mm wide central enamel projection is visible (Fig 1). The left lateral presents with mesial abrasion. The distal CEJ of the first right premolar also displays a concave abrasion with a linear defect at its deepest point.

In the mandible, a right canine: a right central incisor and a left second premolar were not recovered from the excavation site. The mesial aspect of the right second premolar displays concave abrasion, involving the complete height of the crown. Only a mesial sliver of the right lateral incisor crown is intact (Fig 1). Concave abrasions are demonstratable on the mesial and distal surfaces of the right and left lateral crowns respectively. Linear abrasions involve the buccal aspect of the left first and both second molar roots.

Marked attrition, reaching the CEJ, is not unusual in archaelogical material. Smooth concave abrasion of the occlusal surfaces of the anterior teeth is also well-known in habitual clay-pipe smokers (Fig 2). However, the present case with irregular, sharp abrasions is quite different. I have examined over 2,000 medieval skeletons from Britain, Norway and Italy and this is the first time that I have encountered such marked dental abrasion. The appearance does not support deliberate mutilation and I assume that they are occupational, possibly the result of prolonged chewing strands of tough fibres or holding sharp objects between the teeth.

I would be very interested to hear from the readership of British Dental Journal if they have encountered similar abrasions in clinical dentistry and if they have any suggestions as to their aetiology.

T. Anderson, Canterbury

Assessing quality control

Sir,– This autumn my Health Authority informed me that it was now mandatory to have a quality control system in my practice. Areas to be covered were dental care, infection control, radiography, health and safety and continuing professional education.

This is to be applauded, as the health care industry has arguably lagged behind manufacturing in quality control. In these days of evidence based dentistry, it is not acceptable to assume quality is satisfactory without some sort of audit or review.

To set up a comprehensive system we should be randomly sampling 10% or 20% of all finished cases, or the same percentage of every radiograph taken. Staff should be allocated, time set aside, colleagues from other practices invited to carry out the sampling to avoid bias.

Results should be collated, and published, so as to pool information, and prevent the wheel being reinvented every year. I am more than happy to reduce clinical time in the pursuit of modern management ideals but I need adequate payment to do this, if this is to become part of my job description, as I will not be able to treat so many patients, and thus will lose income. What fee is being handed out for this important work? A one off payment of £270. How much time will this purchase? If we had need to engage the services of a highly qualified professional in any industry other than health care, like the law perhaps, they would tell you exactly how perfunctory a service you would get for £270.

We can guess the likely outcome of attempting to get something on the cheap, the same as always in the overworked, underfunded NHS. Poor compliance, totally inadequate systems installed and insufficient time to do the job properly, as we try to cope with our core business, treating patients.

Meantime the Department of Health smugly think that they have reformed a

change resistant profession, and the Treasury congratulate them for keeping costs so low.

The losers, as usual, are the patients, who believe politicians who tell them that there is quality control in NHS dentistry. Is this really the way forward in the new milllenium?

T. Pollard, Sutton

NHS dental treatment

Sir,— I have recently received a supply of NHS leaflets entitled, 'NHS Dental Treatment - What you need to know'. This was accompanied by a leaflet on dental practice information templates. These leaflets seemed to be have been produced in October 2001, but included outdated details of patient charges - which is likely to confuse the patient, as well as taking up the receptionist's (or dentist's) time to explain why the fees were now different to what was stated in the leaflet.

In the 'What you need to know' leaflet, it explains that the benefits of NHS dental care entitle the patient to 'a national set of charges.' Also, any patient receiving Occasional Treatment, can be given a leaflet describing their entitlement as an occasional patient. On phoning to request a supply of both these items, I was informed that they had not yet been printed and could not yet be ordered.

What is the patient going to think of me, when I cannot give them the information to which they are entitled — according to one of the official NHS leaflets that is currently available?

Although I do not criticise the inaccuracy and unavailability of the complete range of leaflets, I am pleased that the Department of Health is trying to inform patients of the current situation with NHS dental treatment, as it is difficult enough for the dental practitioner to understand - never mind the patient!

I firmly believe that the profession should be encouraged to display both their NHS and private charges so that patients are informed and able to decide on the services that they wish to buy. I trust that all future NHS information leaflets are up to date and available to all on request.

I. Auckland, London

Ehlers Danlos syndrome

Sir,— I have recently accepted a young adult with this condition for treatment. She presented with painful, cracking jaws, chronic dislocation and marked bruxism. This was exacerbated by steeply retroclined right central and lateral incisors whose incisal tips are some 4mms inside the arch. I noted an 8mm overbite. Her TMJ symptoms have responded well to a flat occlusal plane appliance but I do not think that I can leave her without treating the orthopaedic/orthodontic problem which I believe is a major factor in her TMJ discomfort.

Ehlers Danlos syndrome is, however, a connective tissue disorder with joint hypermobility and tissue fragility caused by the individual's inability to form collagen fibres. As a condition it is associated with articular pain and joint dysfunction often leading to early onset of osteoarthritis.

There can be irregularities in tooth form and structure with dilaceration and deformity of the roots. In this particular patient the roots are reasonably well formed but only about two thirds normal width and length though tooth crown size is normal.

The relief afforded by her appliance is sufficiently positive for me to want to arrange the orthodontic work but I would like to know of anyone who has actually carried out orthodontic treatment on patients with this syndrome, what the contraindications may be, what special considerations are necessary and what was achieved as a result.

D. Cheetham, Curdridge

Female discrimination?

Sir,— Your editorial and that in the recent BDA News would appear to indicate that a period of positive discrimination is about to start. Your own figures would indicate that women account for 25% of the profession only working two days a week.

Your reasons for women failing to run practices suggests 24 hour emergency cover, personal safety, family problems, stress and the level of remuneration. All of these problems can also occur with male practitioners and they should presumably also employ a chaperone when treating female patients out of surgery hours, adding to their expense.

It would perhaps seem fairer to look at the dental school intake end rather than throwing money at the problem of the failure to keep women in practice. I have the greatest respect for women practitioners who manage the difficult balance between family and work, but I can think of no other business able to keep a quarter of an expensive trained workforce on a two day week.

I. A. Inglis, Plymouth